



MORBIDITY REPORT FORM

Houston Department of Health and Human Services
8000 North Stadium Drive Houston, Texas 77054

1-800-705-8868

Fax: (713)794-9182 [Do NOT fax HIV/AIDS-related patient information]



Reported By : _____ Date : _____
Case Number : _____

PATIENT DEMOGRAPHIC DATA

Last Name : _____ FirstName & MI : _____
DOB : _____ Age : _____ Sex : _____
Race/Ethnicity : _____ SocSecNumber : _____
Address : _____
City, Zipcode : _____ Home Phone : () --
Occupation/Work Place : _____ Tel: () --
School/Day Care Center : _____ Tel: () --
Parent/Contact Person : _____ Tel: () --

DISEASE DATA

Date of Onset: _____
REPORTABLE DISEASE/ORGANISM: _____
Species/serotype : _____

Source of Specimen	Date of Collection	Diagnostic test and Result	Source of Specimen	Date of Collection	Diagnostic test and Result
Specific Viral Hepatitis Studies		Anti-HAV IgM _____ Anti-HAV Total _____	Anti-HBc IgM _____ Anti-HBc Total _____ Anti-HBs _____ HbsAg _____ HbeAg _____	Anti-HCV _____ HCV RIBA _____ HCV RNA by PCR _____	AST/SGOT _____ ALT/SGPT _____

HOSPITAL or CLINIC DATA

Hospital/Clinic : _____ Attending Physician : _____
Medical RecNumber : _____ Address : _____
Date Admitted : _____ Pager/Phone : _____
Date Discharged : _____ Other Physician : _____
Date Expired : _____

Comments/patient history/risk factors:

Investigator: _____

FOR OFFICIAL USE ONLY

FILENO:	RPTBY :	HSA:	INTRV :	STATUS :
KMAP :	CENTRCT:	DX :	OCCUP:	